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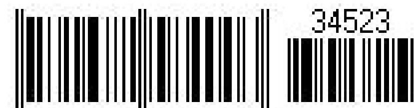

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GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. 657 **12 August 2011**

NATIONAL HEALTH ACT, 2003

POLICY ON NATIONAL HEALTH INSURANCE

The Minister of Health intends, in terms of section 85 of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996) and section 3 of the National Health Act, 2003, (Act No. 61 of 2003) after consultation with the National Health Council, to determine the policy in the Schedule.

Interested persons are invited to submit any substantiated comments or representations on the proposed policy to the Director-General: Health, Private Bag X828, Pretoria, 0001, within a period of two months from the date of publication of this notice.

SCHEDULE

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

POLICY PAPER

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1. INTRODUCTION

1. South Africa is in the process of introducing an innovative system of healthcare financing with far reaching consequences on the health of South Africans. The National Health Insurance commonly referred to as NHI will ensure that everyone has access to appropriate, efficient and quality health services. It will be phased-in over a period of 14 years. This will entail major changes in the service delivery structures, administrative and management systems.

2. The NHI is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status.

3. The current system of healthcare financing in South Africa is two-tiered, with a relatively large proportion of funding allocated through medical schemes, various hospital care plans and out of pocket payments. This current funding arrangement provides cover to private patients who have purchased a benefit option with a scheme of their choice or as a result of their employment conditions. It only benefits those who are employed and are subsidised by their employers – both the State and the private sector. The other portion is funded through the fiscus and is mainly for public sector users. This means that those with medical scheme cover have a choice of providers operating in the private sector which is not extended to the rest of the population.

4. A larger part of the financial and human resources for health is located in the private health sector serving a minority of the population. Medical schemes are the major purchasers of services in the private sector which covers 16.2% of the population (CMS[1], 2009). The public sector is under-resourced relative to the size of the population that it serves and the burden of disease. The public sector has disproportionately less human resources than the private sector yet it has to manage significantly higher patient numbers.

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[1] CMS: Council for Medical Schemes is a statutory body with regulatory oversight for the medical scheme's industry. It is established by an Act of Parliament, the Medical Schemes Act, 1998

5. The South African health system is inequitable, with the privileged few having disproportionate access to health services. There is recognition that this system is neither rational nor fair. Therefore, NHI is intended to ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis. NHI will provide coverage to the whole population and minimise the burden carried by individuals of paying directly out of pocket for healthcare services. This model of delivering health and healthcare services to the population is well accepted, described and widely promoted by the World Health Organisation as universal coverage.

6. To successfully implement a healthcare financing mechanism that covers the whole population such as NHI, four key interventions need to happen simultaneously: i) a ***complete transformation*** of healthcare service provision and delivery; ii) the ***total overhaul*** *of the* entire healthcare system iii) the ***radical change*** *of* administration and management iv) the provision of a comprehensive package of care underpinned by a ***re-engineered Primary Health Care***.

2. PROBLEM STATEMENT

7. Prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefitted the white minority. The other was *systematically* under-resourced and was for the black majority. The Constitution has outlawed any form of racial discrimination and guarantees the principles of socioeconomic rights including the right to health.

8. Attempts to deal with these disparities and to integrate the fragmented services that resulted from fourteen health departments (serving the four race groups, including the ten Bantustans) did not fully address the inequities. Problems linked to health financing that are biased towards the privileged few have not been adequately addressed.

9. Post 1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and it continues to perpetuate inequalities in

the current health system. Attempts to reform the health system have not gone far enough to extend coverage to bring about equity in healthcare.

10. The two-tiered system of healthcare did not and still does not embrace the principles of equity and access and the current health financing mode does not facilitate the attainment of these noble goals.

11. The 2008 World Health Report of the World Health Organisation (WHO) details three trends that undermine the improvement of health outcomes globally, namely:
    - Hospital centrism, which has a strong curative focus
    - Fragmentation in approach which may be related to programmes or service delivery, and
    - Uncontrolled commercialism[2] which undermines principles of health as a public good

12. An analogy of the preceding description can be drawn with the negative attributes of the South African two-tier healthcare system, which are *unsustainable, destructive, very costly and highly curative or hospi-centric*[3].

13. The national health system has a myriad of challenges, among these being the worsening quadruple[4] burden of disease and shortage of key human resources. The public sector has underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure.

14. In many areas access has increased in the public sector, but the quality of healthcare services has deteriorated or remained poor. The public health sector will have to be significantly changed so as to shed the image of poor quality services that have been scientifically shown to be a major barrier to access (Bennett & Gilson, 2003).

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[2] Commercialism – This is a business practice that turns goods and services into products for the sole purpose of generating profits
[3] Hospi-centric – a health system where the majority of health problems are dealt with at hospital level when patients already present with serious complications
[4] Quadruple Burden of Disease: Refers to HIV/AIDS and TB; Maternal and Child death; Non-Communicable diseases and Violence and Injuries

15. Similarly to the public health system, the private sector also has its own problems albeit these are of a different nature and mainly relate to the costs of services. This relates to the pricing and utilisation of services. The high costs are linked to high service tariffs, provider-induced utilization of services and the continued over-servicing of patients on a fee-for-service basis. Evidently, the private health sector will not be sustainable over the medium to long term.

16. To change these types of systems will require *transformation of the healthcare financing model, better regulation of healthcare pricing, improvement in quality of healthcare as well as the strengthening of the planning, information management, service provision and the overhauling of management systems.*

2.1 THE BURDEN OF DISEASE IN SOUTH AFRICA

17. The introduction of NHI, should take into account the burden of disease the country is experiencing. South Africa is plagued by four clear health problems that have been described in the Lancet Report as the quadruple burden of disease (Coovadia *et al,* 2009). These are:
    - HIV/AIDS and TB
    - Maternal, infant and child mortality
    - Non-communicable diseases
    - Injury and violence

2.1.1 HIV/AIDS and TB

18. Despite South Africa only having 0.7% of the world population it carries 17% of HIV infected people in the world. The HIV prevalence is twenty three times the global average, while the TB infection rate is among the highest in the world. Moreover, the TB and HIV/AIDS co-infection rate is one of the highest in the world at 73%. As a result life expectancy in South Africa has declined over a number of years. HIV/AIDS has also contributed significantly to high maternal and child mortality rates. Failure to intervene may reverse 50 years of health gains.

2.1.2 Maternal, Child and Infant Mortality

19. The maternal mortality ratios[5], peri-natal mortality[6] and neonatal mortality[7] rates in South Africa are much higher than that of countries of similar socio-economic development. Maternal mortality has increased markedly in our country, and as previously mentioned HIV/AIDS is the main contributor. However, there are also deaths that are due to largely preventable and non-AIDS related factors. Similarly, infant and child mortality rates have reached unacceptably high levels not only due to HIV and AIDS but also due to other preventable causes.

2.1.3 Non-Communicable Diseases

20. Non-communicable diseases such as high blood pressure, diabetes, chronic heart disease, chronic lung diseases, cancer and mental illnesses contributed to 28% of the total burden of disease measured by disability-adjusted life years in 2004. They are largely driven by four risk factors, namely ***alcohol, smoking, poor diet, and lack of exercise***.

2.1.4 Injury and Violence

21. Injury and violence are also contributing significantly to the burden of disease. Injuries may be categorised as either intentional or unintentional. Of note is the significant proportion of injury associated with *road accidents and inter-personal violence, particularly, violence against women and children.* These are driven largely by high alcohol consumption and other social factors such as poverty and unemployment.

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[5] Maternal Mortality Ratio – This is the number of women who die due to pregnancy related causes and is measured per 100,000 live births in a given population. It includes any pregnancy related death and is measured from the beginning of pregnancy to six weeks after birth or termination of pregnancy.
[6] Peri-Natal Mortality Rate – Peri-natal mortality is the death of a baby who was born live after 20 weeks of pregnancy or dies within 7completed days after birth measured per 1000 births. It includes stillbirths.
[7] Neonatal Mortality Rate – refers to the death of a live born baby within 28 days of birth and is measured per 1,000 live births.

2.2 QUALITY OF HEALTHCARE

22. As mentioned earlier, significant improvements in health services coverage and access since 1994 have been achieved. However, there are still notable quality problems. Among the commonly cited and experienced by the public are: cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs.

23. Given that there are concerns about quality at public sector facilities, there is preference by the public for services in the private sector which may largely be funded out of pocket. Various members of the public cannot afford to make these payments. This type of arrangement is not suitable for the country's level of development. Therefore, improvement of quality in the public health system is at the centre of the health sector's reform endeavours.

2.3 HEALTHCARE EXPENDITURE IN SOUTH AFRICA

24. The World Health Organisation recommends that countries spend at least 5% of their GDP on health care. South Africa already spends 8.5% of its GDP on health, way above what WHO recommends. Despite this high expenditure the health outcomes remain poor when compared to similar middle-income countries. This poor performance has been attributed mainly to the inequities between the public and private sector.

25. It has been reported that high-income countries spent an average of 7.7 percent of their GDP (Gross Domestic Product)[8] on health whilst middle income countries spent 5.8 percent, and low income countries spent 4.7 percent (Schieber, et al 2006).

26. The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2 % in the public sector. The 4.1% spend covers 16.2 % of the population, (8.2 million people) who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population

[8] Gross Domestic Product (GDP) – This is the market value of all final products (goods and services) produced in a country within a given period, usually a financial year.

(42 million people) who mainly utilize the public healthcare sector (National Treasury: Intergovernmental Fiscal Review, 2011).

27. Over the past decade, private hospital costs have increased by 121% whilst over the same period, specialist costs have increased by 120% (CMS Report, 2008). This means that the private healthcare sector will have to accept that the charging of exorbitant fees completely out of proportion to the services provided have to be radically transformed. In real terms, contribution rates per medical scheme beneficiary have doubled over a seven-year period. This has not been proportionate with increased access to services. Simply put this has meant limited access to needed health service coverage mainly as a result of the design of the medical scheme benefit options, or due to early exhaustion of benefits.

28. In South Africa health care expenditure is derived from three main sources: public sector expenditures financed out of general revenue, private sector expenditures financed through medical schemes, and out of pocket payments. This is consistent with expenditure trends as reported by the World Bank (World Bank 2004).

2.4 DISTRIBUTION OF FINANCIAL AND HUMAN RESOURCES

29. The mal-distribution of healthcare resources described above leads to a skewed distribution of key healthcare professionals in favour of the private sector.

30. The recent estimates show that the ratio of patients to health professionals (specialists, general practitioners, pharmacists) is lower in the private sector than in the public sector. There are more professionals per patient in the private sector than the public sector. The Department is finalising its human resources for health strategy in order to the shortages in human resources.

31. The amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity. Per capita annual expenditure for the medical aid group has been estimated at R11,150.00 in contrast to public sector dependant population where the per capita annual health

expenditure is estimated at R2,766.00. This is not an efficient way of financing healthcare.

2.5 MEDICAL SCHEMES INDUSTRY

32. Presently the most reliable source of healthcare financing for individuals is in the form of medical schemes and various hospital cash plans. However, over the years many of them have experienced problems of sustainability. A number of medical schemes have collapsed, been placed under curatorship or merged. They have reduced from over 180 in the year 2001 to about 102 in 2009. This was mainly due to over pricing of health care.

33. In a bid to sustain their financial viability, many schemes resorted to increasing premiums, in many cases at rates higher than CPIX. When this was not successful, the schemes resorted to decreasing members benefits. This has led to an increasing number of members exhausting their benefits midyear or towards the end of the year. This has been worsened by non-health related exorbitant administrator's fees, oversupply of brokers, disproportionate to the membership, and managed care costs. As a result, increased deductions of medical scheme contribution from member's salaries have resulted in wage inflation.

34. However, it is evident that the above measures did not improve or have worsened the cost-escalation because at the centre of this problem is the uncontrolled commercialism of healthcare as described by the World Health Organisation. The intervention by the Competition Commission was also clearly based on the understanding that the scenario is as mapped above. Clearly something completely different is needed in the South African health sector.

2.6 OUT OF POCKET PAYMENTS AND CO-PAYMENTS

35. Out of pocket payment accounts for a significant part of total health expenditure and this could be in the form of co-payments, or direct payment to private providers particularly by those who are not covered by medical schemes. Even for those who are covered by medical schemes, the extent of co-payments confirms that the current system does not

provide full cover. However, for those who are not on medical aid this could have catastrophic[9] effects.

36. Payment for health care, particularly for those who cannot afford and who pay out of pocket cannot be planned in advance and this lack of predictability is what exposes households to financial hardships.

37. Evidence has demonstrated that those who are not adequately covered by any form of health insurance are among others women; children; the elderly; low income groups etc. It is for this reason that coverage should be extended to all these populations (Meng, 2011).

3. HISTORY OF PROPOSALS ON HEALTHCARE FINANCING REFORM IN SOUTH AFRICA

38. Contrary to common belief, the history of reforming the healthcare financing system in South Africa actually dates back more than 80 years:

3.1 Commission on Old Age Pension and National Insurance (1928)

39. A Commission on Old Age Pension and National Insurance recommended that a health insurance scheme should be established to cover medical, maternity and funeral benefits for all low income formal sector employees in urban areas.

3.2 Committee of Enquiry into National Health Insurance (1935)

40. A Committee of Enquiry into National Health Insurance recommended in 1935 similar proposals as those made in 1928. Neither of the proposals of these two Committees was ever taken forward.

[9] Catastrophic health expenditure – health care expenditure resulting from severe illness/ injury that usually requires prolonged hospitalisation and involves high costs for hospitals, doctors and medicines leading to impoverishment or total financial collapse of the household.

3.3 National Health Service Commission (1942 – 1944)

41. A Commission led by Dr. Henry Gluckman was set up in this period. It was called the National Health Service Commission. It recommended the implementation of a National Health Tax to ensure that health services could be provided free at the point of service for all South Africans. The aim was to bring health services *"within reach of all sections of the population, according to their needs, and without regard to race, colour, means or station in life"*. Health centres, providing comprehensive primary care services, were proposed as a core component of the health system.

42. Although the Gluckman Commission proposals were accepted by the government led by General Jan Smuts, it was decided to implement them as a series of measures rather than in a single step. The introduction of Community-based centres was taken forward with 44 centres being in operation within two years, but other aspects of the proposals were never implemented. Any gains from the Gluckman Commission process were reversed after the National Party (NP) government led by General DF Malan was elected in 1948.

3.4 Health Care Finance Committee (1994)

43. By the early 1990s, the spotlight had again turned to the possibility of introducing some form of mandatory health insurance and after the 1994 elections; there were several policy initiatives that considered either social or national health insurance. The Healthcare Finance Committee of 1994 recommended that all formally employed individuals and their immediate dependents should initially form the core membership of social health insurance arrangements with a view to expanding coverage to other groups over time.

44. It was also suggested that there should be a multi-funder (or multi-payer) environment and that private funders, namely medical schemes, should act as financial intermediaries for channelling funds to providers. It was also proposed that there should be a risk-

equalization[10] mechanism between individual insurers to help stabilise the medical schemes industry. It was further recommended that a comprehensive set of services be covered under such a system and that both public and private providers will be involved in the delivery and provision of these services. The main challenge with respect to these sets of recommendations was the inability of the State to fully finance the recommended package of services.

3.5 Committee of Inquiry on National Health Insurance (1995)

45. The 1994 Finance Committee was followed by the 1995 Commission of Enquiry on National Health Insurance which fully supported the recommendations of the Health Finance Committee. The key difference was on the benefit package. This committee as well as the healthcare finance committee made a strong case for primary health care services.

3.6 The Social Health Insurance Working Group (1997)

46. In 1997 the Social Health Insurance Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act in 1998. This Act was meant to regulate the private health insurance as well as to entrench the principles of open enrolment, community rating, prescribed minimum benefits and better governance of medical schemes. However, despite the introduction of the Act and the supporting principles the level of coverage for the national population has remained below 16 percent and is only affordable to the relatively well-off.

3.7 Committee of Inquiry into a Comprehensive Social Security for South Africa (2002)

47. In 2002, Department of Social Development appointed Professor Vivienne Taylor to chair the Committee of Inquiry into a Comprehensive Social Security for South Africa. The Commission recommended that there must be mandatory cover for all those in the formal

[10] Risk Equalisation – This is a mechanism that is applied to equalise the risk profiles of separate insurance pools in order to avoid loading premiums on the insured members based on some pre-determined health factors

sector earning above a given tax threshold and that contributions should be income-related and collected as a dedicated tax for health. The Committee also recommended that the State should create a national health fund through which resources should be channelled to public facilities through the government budget processes.

3.8 Ministerial Task Team on Social Health Insurance (2002)

48. To implement the recommendations of the Taylor Committee, the Department of Health established the Ministerial Task Team on Social Health Insurance in 2002 to draft an implementation plan with concrete proposals on how to move towards social health insurance and to create supporting legislative and institutional mechanisms that will in the long term result in the realisation of National Health Insurance in South Africa. However, the path to achieving universal coverage through a social health insurance model was not widely supported and the implementation of the supporting proposals thus stalled.

3.9 Advisory Committee on National Health Insurance (2009)

49. In August 2009, the Ministerial Advisory Committee on National Health Insurance was established which had been tasked with providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system reforms and matters relating to the design and roll-out of National Health Insurance. This was to carry forward the Resolution passed at the ruling party's (ANC) Conference in December 2007 in Polokwane. This was Resolution 53 which called for the establishment of a National Health Insurance.

4. NATIONAL HEALTH INSURANCE

50. The rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. National Health Insurance will improve access to quality healthcare services and provide financial risk protection against health-related catastrophic expenditures for the whole population. Such a system will provide a

mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. Moreover, by significantly reducing direct costs for health care, families and households under National Health Insurance are less likely to face impoverishing health care costs.

51. NHI will ensure that everyone has access to a defined comprehensive package of healthcare services. The covered healthcare services will be provided through appropriately accredited and contracted ***public and private providers*** and there will be a strong and sustained focus on the provision of ***health promotion and prevention services*** at the community and household level.

5. PRINCIPLES OF NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

52. The National Health Insurance will be guided by the following principles:

a) **The Right to Access** – Section 27 of the Bill of Rights of the Constitution states that everyone has a right of access to health care services including reproductive health care and that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights. The reform of healthcare is an important step towards the realisation of these rights and the key aspect of this is that access to health services must be free at the point of use and that people will benefit according to their health profile.

b) **Social Solidarity** – this refers to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. Such a system allows for the spreading of health costs over a person's lifecycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life.

c) **Effectiveness** – this will be achieved through evidence based interventions, strengthened management systems and better performance of the healthcare system

that will contribute to positive health outcomes and overall improved life expectancy for the entire population.

d) **Appropriateness** – this refers to the adoption of new and innovative health service delivery models that take account of the local context and acceptability and tailored to respond to local needs. The health services delivery model will be based on a properly structured referral system rendered via a re-engineered Primary Health Care model.

e) **Equity** – this refers to the health system that ensures that those with the greatest health need are provided with timely access to health services. It should be free from any barriers[11] and any inequalities in the system should be minimised. Equity in the health system should lead to expansion of access to quality health services by vulnerable groups and in underserved areas. The principle of equity has been elaborately articulated as *fairness* by the Director-General of the WHO, Dr. Margaret Chan (see box insert).

> Dr. Margaret Chan Address to the United Nations General Assembly on the theme "Advancing Global Health in the Face of Crisis", 15 June 2009:
> ***"Fairness, I believe, is at the heart of our ambitions in global health. A quest for greater fairness dominates the agenda for this forum. We see this in your concern about vulnerable populations, and about health systems that exclude the poor. We see this in your support for global health initiatives and funding mechanisms that redistribute some of the world's riches towards health needs of the poor. On the issue of fairness, let me again state the obvious. Our world is dangerously out of balance, also in matters of health. Differences, within and between countries, in income levels, opportunities and health status are greater today than at any time in recent history. Part of the world feasts itself into obesity, while part of the world fasts and starves for want of food. Part of the world thrives into old age, while part of the world dies young from easily and cheaply preventable causes. As the historians tell us, such huge extremes of privilege and misery are a precursor for social breakdown. Is this where the progress of our civilized, advanced, high-tech, sophisticated society has brought us? To the brink of social breakdown? Let me make another obvious point. A health system is a social institution. It does not just deliver pills and babies the way a post office delivers letters. Properly managed and financed, a health system that strives for universal coverage contributes to social cohesion and stability. I further believe that a failure to make fairness an explicit objective, in policies, in the systems that govern the way nations and their populations interact, is one reason why the world is in such a great big mess".***

f) **Affordability** – this means that services will be procured at reasonable costs that recognise health as not just an ordinary commodity of trade but as a public good.

[11] Barriers may be regulatory, cultural, geographic and administrative. This should be understood within available resources in the country.

g) **Efficiency** – this will be ensured through creating administrative structures that minimize or eliminate duplication across the national, provincial and district spheres. The key will be to ensure that minimal resources are spent on the administrative structures of the National Health Insurance and that value-for-money is achieved in the translation of resources into actual health service delivery.

6. OBJECTIVES OF NATIONAL HEALTH INSURANCE

53. National Health Insurance is aimed at providing universal coverage. Universal coverage as defined by WHO "is the progressive development of a health system including its financing mechanisms into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services".

54. A number of countries have reformed their health systems to achieve the above goals. This has brought about equity in access for needed services, administrative efficiency, increased revenue and quality improvements.

55. The objectives of National Health Insurance are:
    a) To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not.
    b) To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.
    c) To procure services on behalf of the entire population and efficiently mobilize and control key financial resources. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling costs.
    d) To strengthen the under-resourced and strained public sector so as to improve health systems performance

7. SOCIOECONOMIC BENEFITS OF NATIONAL HEALTH INSURANCE

56. Health affects social development and economic productivity in four ways. These are namely through (i) increased output as a healthy person works more effectively and efficiently and devotes more time to productive activities (i.e. fewer days off, longer work life span); (ii) a broader knowledge base in the economy as the gains to education increase as life expectancy increases; (iii) increased "work life" and savings as a result of increased life expectancy may result in earning and saving more for retirement; and (iv) an increase in labour force activity. These benefits include having a healthier population, which in turn translates into a productive and effective workforce that grows local business, attracts foreign investors and grows the domestic economy.

57. This argument was effectively elaborated by the Secretary General of the United Nations, Mr. Ban Ki Moon, at the 2009 United Nations General Assembly on the theme "Advancing Global Health in the Face of Crisis", when he said:

> *"We can cut back on health expenditures and incur massive losses in lives and fundamental capacity for growth. Or we can invest in health and spare both people and economies the high cost of inaction. The cost of cutting back is just unthinkable. I know that many in this audience do not need to be told about the significant returns we see from investing in health. Investments to scale up basic health services can bring a six-fold economic return. Healthy people have improved life expectancy, go to school, are more productive, take fewer days off of work, have lower birth rates and thus invest more in fewer children".*

58. In other middle-income countries where National Health Insurance has been implemented it has resulted in the following benefits:

    a) A healthier population contributes to better wealth creation. Each extra year of life expectancy raises a country's GDP per person by around 4% in the long run. Poor health reductions in adult mortality explain 10 to 15 percent of the economic growth that occurred from 1960 to 1990 in 52 countries (Bloom, D.E, Canning, D., & Sevilla, J (2003) *The Effect of Health on Economic Growth: A Production Function Approach*. World Development 32(1): 1-13).

b) Investments in health are important safety nets against poverty traps in times of economic upheaval. Lack of health insurance in India means that over 37 million Indians fall below the poverty line each year due to catastrophic health spending; families will often sell assets like livestock in order to meet medical expenses.

c) Public financing of health services frees the poor to use more money to improve their welfare and create jobs for others. For example, in South Africa, 48% of health spending flowed via private intermediaries in the way of private health insurance contributions (40.7%) and the remainder is out of pocket spending. If the households did not have to spend this on health, they would either save it or spend it on other goods and services including investing in other household assets, and other activities that create jobs in the economy.

59. In Mexico the introduction of universal coverage linked to innovative initiatives to tackle their double burden of disease enhanced the basic capabilities of families living in extreme poverty. The interventions included basic sanitation, reproductive health, nutritional and growth surveillance, and specific prevention measures mostly for communicable diseases, but increasingly also for high blood pressure, diabetes and injury (Frenk 2006).

60. The country will have a healthier workforce at a lower cost in the long term, which increases employment and attracts foreign direct investment. For instance, Canada's provinces introduced national health insurance on a staggered basis from 1961 – 1975. Across 8 industries in 10 provinces, employment rose after the introduction of National Health insurance; wages increased as well, but average hours were unchanged. In addition, provinces with high initial levels of private insurance coverage had lower rates of employment and slower wage growth.

7.1 Economic Impact Modelling[12]

61. Macro-economic modelling undertaken suggests that the implementation of National Health Insurance could have positive or negative implications, depending on the model utilized and its outcomes. When implemented successfully, the National Health Insurance can improve employment and growth in the long-run. The economic impact assessment indicates that the National Health Insurance can have positive impacts in the long-run provided that it succeeds in improving the health indicators of the country, including significant improvement in life expectancy and child mortality. The better health outcomes need to translate into significant labour productivity. In the long-run, the higher productivity can lead to growth improving by 0.5 percentage points. However for National Health Insurance to have this positive macro-economic implication it needs to address the current institutional and staff constraints, improve significantly South Africa's health indicators, achieve the productivity gains and remain affordable.

8. THE THREE DIMENSIONS OF UNIVERSAL COVERAGE

62. In the 2010 World Health Report, the WHO provides guidance to countries on achieving universal healthcare coverage and social solidarity. It recommends three dimensions of progressing towards universal coverage and these have been identified as follows:

a) Population Coverage

It refers to the proportion of the population that has access to needed health services.

b) Service Coverage

It refers to the extent to which a range of services necessary to address health needs of the entire population are covered.

c) Financial Risk Protection

It refers to the extent to which the population is protected from catastrophic health expenditure particularly for households.

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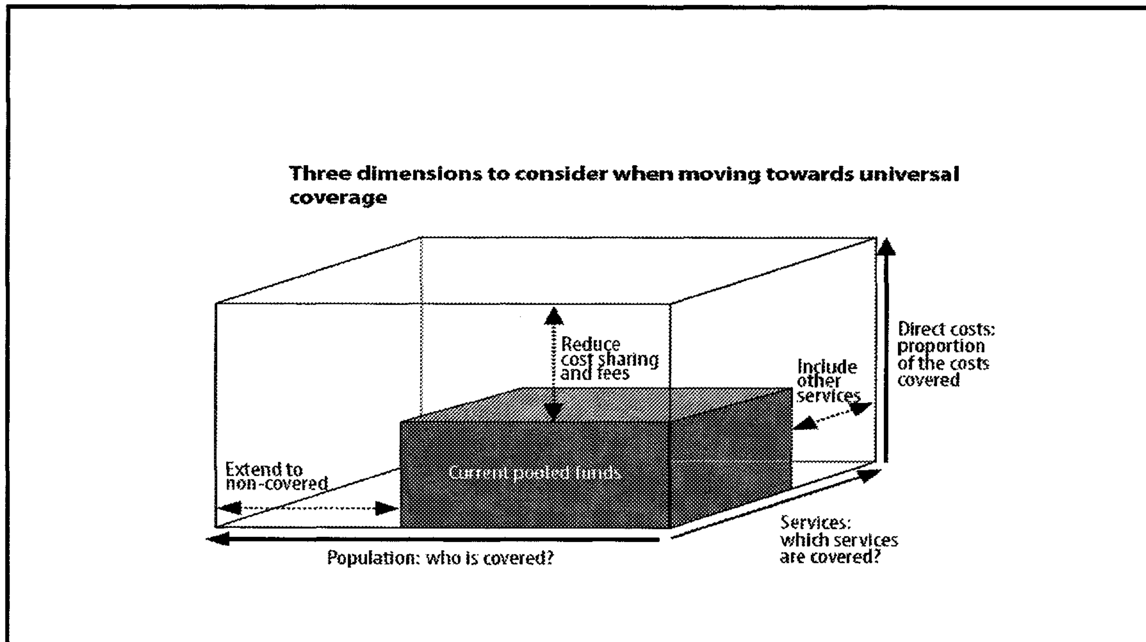
[12] National Treasury (2010) Economic Impacts of the National Health Insurance. *Draft.*

63. In a simplified diagrammatic form, the three dimensions may be summarized in the following figure:

Figure 1: The three dimensions of moving towards universal coverage



a) Length of the cube

This refers to the population coverage under universal coverage where the whole cube is covered and not just a portion of it.

b) Breadth of the cube

This refers to services covered. The present system wrongly confuses healthcare with treatment of diseases. A comprehensive healthcare package includes:

- Prevention of diseases, Promotion of health, Treatment of diseases where prevention has failed, Rehabilitative services

c) Height of the cube

This refers to the extent to which individual households are protected from exposure to financial risks associated with health. As previously stated, households exposed to financial risks due to illnesses are sometimes driven into poverty.

9. POPULATION COVERAGE UNDER NATIONAL HEALTH INSURANCE

64. National Health Insurance will cover all South Africans and legal permanent residents. Short-term residents, foreign students and tourists will be required to obtain compulsory travel insurance and must produce evidence of this upon entry into South Africa. Refugees and asylum seekers will be covered in line with provisions of the Refugees Act, 1998 and International Human Rights Instruments that have been ratified by the State.

65. In extending coverage the population that is in greatest need should be defined and the coverage must include those experiencing greatest difficulty in obtaining care. The identification of the population with the greatest need will be based on objective criteria.

10. THE RE-ENGINEERED PRIMARY HEALTH CARE SYSTEM

66. The strengthening of the South African health system will be based on a Primary Health Care approach. This will be rooted in the primary health care philosophy. The centrality of Primary Health Care was more clearly outlined by the WHO in the international conference on PHC held in Alma Ata, Kazakstan in 1978 when they redefined health as follows:

    "Health is not just the absence of disease or infirmity but a state of complete physical, mental and social wellbeing. It is a fundamental human right and the attainment of the highest possible level of health is the most important worldwide social goal whose realisation requires action from many other social and economic sectors in addition to the health sector".

    In South Africa, PHC services will be re-engineered to focus mainly community outreach services. Ongoing efforts to reengineer the PHC approach will ensure that the composition of a defined comprehensive primary care package of services extends beyond services traditionally provided in health facilities such as clinics, community health centres and district hospitals.

67. Primary health care services will be re-engineered to focus mainly on health promotion, preventative care, whilst also ensuring that quality curative and rehabilitative services

appropriate to this level of care are rendered. Work is already underway in the National and Provincial Departments of Health to support the delivery of primary health care services. These services will be population orientated with extensive community outreach and home based services, and in which community health workers form an essential part. The district health system (DHS) will be the vehicle by which all PHC is delivered.

68. It has been shown that there is a strong support for inclusion of Primary Health Care services within the benefit package for mandatory insurance. This should also include private sector primary care services. This has the potential to reduce the disparities that exist in the distribution of human resources between the public and private sector.

69. All members of the population will be entitled to a defined comprehensive package of health services at all levels of care namely: primary, secondary, tertiary and quaternary with guaranteed continuity of healthcare benefits.

70. Primary health care services shall be delivered according to the following three streams:
    a) District-based clinical specialist support teams supporting delivery of priority health care programmes at a district
    b) School-based Primary Health Care services
    c) Municipal Ward-based Primary Health Care Agents

10.1 District Clinical Specialist Support Teams

71. In order to address high levels of maternal and child mortality and to improve health outcomes, an integrated team of specialists will be based in the districts. The specialities will include: ***a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal primary health care professional nurse***. Others will be added over time as the need arises. The role of these teams will be to provide clinical support and oversight particularly in those districts with a high disease burden.

72. The health districts in South Africa have for a long time lacked specialist resources to provide support to primary healthcare services. With the increased shortage in specialist

health professionals, the gap in specialist support has become wider and continues to reduce access for vulnerable populations and increases the total cost of medical care. The objectives of the district clinical specialist support teams will be :

- To promote innovative models of providing specialist healthcare closer to the patients' home
- To promote integrated working practices between GPs and hospital based specialists
- To improve the quality of services rendered at the first level of care by ensuring adherence to treatment guidelines and protocols
- To provide peer support for specialists working in primary care.

73. These innovative approaches can improve access, outcomes and service utilisation especially when delivered as a multi-faceted approach. Evidence from the Cochrane systematic review indicates that in contexts where specialist medical practitioners have been involved in primary care clinics and rural hospital settings it has led to increasing the accessibility and effectiveness of specialist services and their integration with primary care services (Gruen, et al. 2009). Contrary to the norm of clinical specialist outreach services, these are not outreach specialists. They will be an integral and permanent feature of health care delivery in South Africa. The medical schools in the country should be able to provide these teams, even if it is on a rotational basis.

    This model is also cost effective as patients will be seen early by specialists before they are too ill and need advanced technology and treatment at higher levels. It will also address the problems associated with delays in referral or poor access to needed specialist services.

10.2 School Health Services

74. School health services will be delivered by a team that is headed by a professional nurse. The services will include health promotion, prevention and curative health services that address the health needs of school-going children, including those children who have missed the opportunity to access services such as child immunization services during their pre-school years.

75. School health is an integral part of the comprehensive package of primary health care services that must be delivered to every school in the district. The school-based health programme will ensure that the general state of physical, mental health and well-being of school going children including pre-Grade R, and Grade R up until Grade 12.

76. The other areas of the school health programme will include a focus on child and sex abuse, oral health services, vision screening services, eradication of parasites, nutritional services, substance abuse, sexual and reproductive health rights including family planning services, and HIV and AIDS related programmes.

10.3 Municipal Ward-based Primary Health Care Agents

77. A team of PHC agents will be deployed in every municipal ward. At least 10 people will be deployed per ward. Each team will be headed by a health professional depending on availability. Each member of the team will be allocated a certain number of families.

78. The teams will collectively facilitate community involvement and participation in identifying health problems and behaviours that place individuals at risk of disease or injury; vulnerable individuals and groups; and implementing appropriate interventions from the service package to address the behaviours or health problems.

11. HEALTHCARE BENEFITS UNDER NATIONAL HEALTH INSURANCE

79. The provision of a comprehensive benefit package of care under National Health Insurance will be fair and rational. The term 'benefit package' describes how different types of services are organized into different levels of care in the public sector (J Doherty, 2010). It also defines the types of services that are considered as achievable for the country commensurate with its resources.

80. The National Department of Health (NDOH) has over the number of years developed 'benefit packages,' for primary health care, district hospital services, regional hospital

services and tertiary services. Despite this, barriers to accessing these packages still exist.

81. In the design of these packages, certain considerations should be made to overcome the identified barriers to access. A review of the international evidence on high-level strategies to promote health and health equity found that comprehensive benefit packages should be determined first by considering which interventions are important in improving access, offering financial protection to less advantaged groups and enhancing redistribution of healthcare services. The comprehensiveness of the package of services to be provided must also demonstrate how well the health system is performing, and ensure timely referral of patients at different levels of care.

82. The norms and standards for the package to be provided in the district will assist in outlining precisely the measurable targets which must be achieved and the acceptable standards of care which providers must comply with. These will enable managers at facility, district, provincial and national levels to compare performance and challenges between individual and groups of similar facilities.

11.1 The Service Package within the Context of District Heath Services

83. Services provided within the context of the district health system have shown mixed results purely because they have been viewed as a once off process of granting authority to lower levels of administration in a decentralised manner. Evidence shows that this must be a carefully planned process that requires good administrative systems with innovative service delivery approaches that would bring about efficiency, improved management including financial management.

84. A district health package of public health and clinical interventions, which are highly cost-effective and deal with major sources of disease burden, through the three PHC streams involving various teams, can be provided in South Africa at reasonable cost. Properly delivered through the primary health care streams, this package could eliminate 21% to 38% of the burden of premature mortality and disability in children under 15-years of age, and 10% to 18% of the burden in adults (Bobadilla, 1994).The district health package is designed to meet the needs of the population. Some of the issues to be addressed are:

- Availability of health services at adequately convenient hours with enough professional staff to attend to their needs
- Consideration of the user's privacy, confidentiality, fair treatment by staff members and ensuring the user's dignity is respected at all times
- Compliance with core quality standards

11.2 Delivery of Primary Health Care Services through Private Providers

85. In addition to the three streams, PHC services will be delivered through accredited and contracted private providers practicing within a District. A sizeable proportion of the population in the country uses private providers for their health care needs and more often than not it involves substantial out of pocket payment.

86. There are several ways in which private providers could participate in providing PHC services to the population. The salient feature of contracting private providers in the delivery of primary health care services will entail the specification of the range of services that will be provided. These may include services by the general practitioners to patients who must get the full range of primary care services required in one facility or comparable arrangement which does not inconvenience or require travel costs on the part of the patient.

11.3 Hospital-Based Benefits

87. Services to be rendered at the hospital level will be based on a defined comprehensive package that is appropriate to the level of care and referral systems[13]. The National Health Insurance will provide an evidenced-based comprehensive package of health services which includes all levels of care namely: primary, secondary, tertiary and quaternary health care services.

[13] The channelling of a patient to another level of care, either a higher or lower level for continuity of care. It is a process in which the treating health practitioner at a particular level of health service channels a patient to a different level of care.

11.4 Designation of Hospitals

88. As part of the overhaul of the health system and improvement of its management, hospitals in South Africa will be re-designated as follows:
    - District hospital;
    - Regional hospital;
    - Tertiary hospital;
    - Central hospital; and
    - Specialized hospital.

    Each level of hospital designation will be managed at a newly defined level with appropriate qualifications and skills as defined by the National Health Council.

89. It is recognized that health care services in South Africa are rendered at different levels of care with specific core packages. Patients and/or members of the public should be able to access the care needed at the time of need. This should be part of the system design and operations with appropriate guarantee of patient safety.

District hospitals

90. This is the smallest type of hospital which provides generalist medical services. In terms of specialist care, they are limited to four basic areas namely:
    - Obstetrics and Gynaecology
    - Paediatrics and Child Health
    - General Surgery
    - Family Medicine

91. The package of care provided at district hospitals includes trauma and emergency care, in-patient care, out-patient visits, rehabilitation services, geriatric care, laboratory and diagnostic services, paediatric and obstetric care.

92. Consequently in the South African context these facilities will have anaesthesia administered at the general practitioner level, within a theatre complex. These facilities will be supported by the district specialist teams within a broad PHC service package.